

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

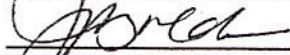
PRINTED: 09/01/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445419	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/18/2016
NAME OF PROVIDER OR SUPPLIER OVERTON COUNTY HEALTH AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 318 BILBREY STREET LIVINGSTON, TN 38570		
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F 000	INITIAL COMMENTS	F 000			
F 281 SS=D	<p>During complaint investigation of #38190 and 38507 conducted on 8/15/16 - 8/18/16 at Overton County Health and Rehab Center, no deficiencies were cited in relation to #38507 under 42 CFR PART 483, Requirements for Long Term Care Facilities.</p> <p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on facility policy review, medical record review, and interview, the facility failed to follow their policy to obtain urine cultures for residents with cloudy urine for 1 (Resident #4) of 6 residents reviewed.</p> <p>The findings included:</p> <p>Review of policy entitled Culture tests and confirmed by the DON on 8/16/16 at 3:30 PM as being the policy the facility currently follows, revealed "...Urine cultures may be obtained by the Charge Nurse if a resident develops cloudy urine or other signs of urinary tract infection. An order from the physician must be obtained before the specimen is sent to the laboratory..."</p> <p>Medical record review revealed Resident #4 was admitted to the facility on 12/22/15 with diagnoses including Hypertension, Diabetes Mellitus, Emphysema, Gastroesophageal Reflux Disease, Morbid Obesity, Chronic Obstructive Pulmonary</p>	F 281			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE



Administrator

9/19/16

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 281	<p>Continued From page 1</p> <p>Disease, Clostridium Difficile Infection, and Methicillin Resistant Staphylococcus Aureus Bacteremia.</p> <p>Medical record review of the Admission Minimum Data Set (MDS) dated 12/22/15 revealed Resident #4 scored 4/15 on the Brief Interview for Mental Status indicating she was severely impaired cognitively. Continued review of the MDS revealed Resident #4 was totally dependent on 2 staff for transfers and bathing; was totally dependent on 1 person for eating; required extensive assistance of 2 people for dressing and grooming; had a Foley catheter in place; and was frequently incontinent of bowel.</p> <p>Medical record review of a communication with the physician dated 12/29/15 revealed "...Family noted dark colored urine which they verbalized was indicative of a UTI (urinary tract infection). May we obtain UA (urinalysis) to verify?..." Continued review revealed the physician responded on 1/2/16 to obtain one by an in and out catheterization. Further review revealed a note from the physician's office dated 1/4/16 stating "...do not obtain UA D/T (due to) ABT (antibiotics) in use..."</p> <p>Medical record review of nursing notes dated 1/13/16 revealed Resident #4 had a Foley catheter which was draining cloudy urine with sediment. Continued review of notes dated 1/15/16 revealed the Foley catheter was draining cloudy yellow urine with moderate amount of sediment. Further review of nursing notes dated 1/19/16 revealed the Foley was draining cloudy yellow urine with sediment. Continued review of nursing notes dated 1/23/16 revealed Foley catheter was patent draining cloudy yellow urine.</p>	F 281	<p>F 281 483.20 (k)(3)(i) Services Provided Meet Professional Standard</p> <p>Resident #4</p> <p>1) Resident #4 discharged on 1/27/2016. On 9/08/16, the DON with Medical Director approval revised the following policies "Urinary Tract Infections/Bacteriuria-Clinical Protocol" and "Cultures" which removes a charge nurse from ordering UA/Cultures but requires a MD order and facility must follow the Revised MCGeer Criteria recommend by CDC. These policies will be presented at the 9/21/16 QAPI committee meeting for approval and the Board meeting on 9/22/16. Attachment# 1 – Revised Policies.</p> <p>2) Beginning 9/1/16, the Infection Control Coordinator will track all residents for signs and symptoms of Urinary Tract Infections using the McGeer Criteria recommended by CDC and provide a Trending Report" that will be presented to the QAPI Committee quarterly. Attachment #2: UTI Trending Report.</p> <p>3) On 09/20/16, a mandatory in-service will be conducted by the DON with all licensed nursing staff (RNs & LPNs) on revised policies "Cultures and Urinary Tract Infections/Bacteriuria – Clinical Protocol" using the McGeer Criteria recommended by the CDC for signs and symptoms of Urinary Tract infections. Nursing staff will use these criteria to monitor all residents for signs and symptoms and must have MD order to collect UA/Culture. Any RN or LPN not attending mandatory in-service will not be allowed to work until they have attended the missed in-service.</p>		

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F 281	Continued From page 2 Further review of nursing notes dated 1/24/16 revealed the Foley was draining light yellow urine. Review of physician communications revealed no documentation the physician was notified of the cloudy urine with sediment. Further review revealed no nursing orders for a urinalysis as per policy. Continued review of the History and Physical from the hospital revealed one of the admitting diagnoses was sepsis due to urinary tract infection. Interview with the DON on 8/16/16 at 2:20 PM in the Administrator's office, revealed Resident #4 was receiving Vancocin 250 milligrams four times daily for Clostridium Difficile infection from admission and it was discontinued on 1/22/16. In continued interview the DON confirmed a urine culture should have been sent 3 days after completion of the antibiotics which was facility policy and would have been 1/25/16 but a culture was not sent. In further interview the DON confirmed the policy on Culture Tests was the one currently in use in the facility and there was a statement the charge Nurse could order a urinalysis if a resident had cloudy urine and no culture was ordered.	F 281	Beginning 9/08/16 the DON and/or designee will monitor 100% of residents using the McGeer Criteria for signs and symptoms of a UTI for two months to ensure compliance with the new policies. The Infection Control Coordinator will conduct Quarterly In-Services on Cultures and CDC criteria beginning 9/1/16. 4) Beginning 9/21/16, the DON will report to the QAPI Committee concerning the monitoring outcomes of UTIs, Cultures ordered and the number of Antibiotics ordered. The Administrator will report to the Governing Body concerning the monitoring outcomes on a quarterly basis beginning 9/22/16.	9/22/16	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and	F 314			

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F 314	<p>Continued From page 3 prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by: Based on facility policy review, medical record review, and interview, the facility failed to assess pressure ulcers accurately and measure ulcers in a consistent manner for 1 (Resident #4) of 6 residents reviewed.</p> <p>The findings included:</p> <p>Review of facility policy entitled Skin/Wound Management Protocols in the section on Unstageable Pressure Ulcer or Full Thickness Wounds with Eschar or Slough revealed unstageable is defined as "...full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green, or brown) and/or eschar (tan, brown, or black) in the wound bed..." Topical wound management includes selecting a product that will promote moist wound healing properties. Dressing choice should be determined by wound characteristics such as size, depth, amount of drainage. If the wound does not progress within 2-4 weeks contact a physician for further evaluation.. For wound with dead space (craters) gently fill with dressing product but do not pack tightly as this will impede healing. Monitor patient for signs and symptoms of infection.</p> <p>Medical record review revealed Resident #4 was admitted to the facility on 12/22/15 with diagnoses including Hypertension, Diabetes Mellitus, Emphysema, Gastroesophageal Reflux Disease, Morbid Obesity, Chronic Obstructive Pulmonary Disease, Clostridium Difficile Infection, and</p>	F 314	<p>F 314 483.25 (c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>1) Resident # 4 was discharged on 1/27/2016. On 8/16/16 the DON acknowledged that the wound care nurse working at the time of the inconsistent measurements was replaced with the current wound care nurse 2 1/2 months ago.</p> <p>On 9/7/16 the Administrator approved the purchase of a camera for use by the wound care nurse to make pictures of wounds when residents are admitted, upon transfer to another level of care and on discharge.</p> <p>On 9/8/16 the DON developed a policy for use of camera by wound care nurse and revised the Wound Care Assessment policy. Attachment #3 Policies.</p> <p>2) Beginning 9/15/16, the wound care nurse will begin using the camera on all residents admitted with wounds or wounds developed in-house and report the number of photos taken on a monthly basis to the QAPI Committee quarterly. All photos with discrepancies on readmissions or transfers will be recorded on quarterly report. The Director of Nursing will monitor all wound care measurements and assessments for one month to assure compliance of new wound care assessment policy and accuracy of measurements.</p> <p>3) On 09/20/16, a mandatory in-service was conducted by the DON with all licensed nursing staff (RNs & LPNs) on revised policies "Photos of Wounds" and "Wound Care Assessment". Any RN or LPN not attending mandatory in-services will not be allowed to work until they have attended the missed in-service.</p>		

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F 314	<p>Continued From page 4</p> <p>Methicillin Resistant Staphylococcus Aureus Bacteremia.</p> <p>Medical record review of the Admission Minimum Data Set (MDS) dated 12/22/15 revealed Resident #4 scored 4/15 on the Brief Interview for Mental Status indicating she was severely impaired cognitively. Continued review of the MDS revealed Resident #4 was totally dependent on 2 staff for transfers and bathing; was totally dependent on 1 person for eating; required extensive assistance of 2 people for dressing and grooming; had a Foley catheter in place; and was frequently incontinent of bowel.</p> <p>Medical record review of the Nursing Admission Assessment dated 12/22/15 revealed Resident #4 had an excoriated area to the right anterior thigh, skin tear to left posterior shoulder, and a skin tear to the right inner thigh. Continued review revealed "...Multiple pressure areas noted to buttocks et coccyx area..."</p> <p>Medical record review of wound care notes revealed Resident #4 was admitted with a skin tear to the right upper shoulder measuring 1.5 centimeters (cm) x (by) 1.0 cm with the edges not well approximated. Continued review revealed Resident #4 was also admitted with a skin tear to the right breast measuring 1.5 cm x 3.0 cm with its edges not well approximated. Further review revealed Resident #4 was also admitted with a ruptured blister to the right inner thigh measuring 2.5 cm x 1.5 cm with scant serous drainage. Continued review revealed Resident #4 was admitted with a sacral pressure ulcer which was unstageable due to slough but measured 6.0 cm x 9.0 cm x 4.0 cm. Continued review revealed the wound bed was 75% eschar and 25% slough</p>	F 314	<p>Beginning 9/15/16 The Director of Nursing will monitor all residents wound care measurements, assessments, and photos of their wounds to ensure compliance with the new policies.</p> <p>4) Beginning 9/21/16, the DON will report to the QAPI Committee concerning the monitoring of outcomes of accurate measurements, assessments, and photos of resident wounds. The Administrator will report to the Governing Body concerning the monitoring outcomes on a quarterly basis beginning 9/22/16.</p>		9/22/16

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F 314	<p>Continued From page 5</p> <p>with macerated borders of the wound and a moderate amount of serosanguinous drainage.</p> <p>Medical record review of wound care notes dated 12/30/15 revealed the sacral wound measured 8.5 cm x 10 cm x 3.8 cm with 75% eschar and 25% slough. Continued review revealed the wound bed was covered with Silvadene cream and the wound was packed with gauze.</p> <p>Medical record review of wound care notes dated 1/10/16 revealed the sacral wound was still unstageable and measured 11.0 cm x 7.0 cm x 3.5 cm with 25% epithelialization and 75% slough.</p> <p>Medical record review of wound care notes dated 1/20/16 revealed the sacral wound was still unstageable and measured 10.0 cm x 9.0 cm x 3.0 cm. Continued review revealed the wound bed was 100% slough with purulent drainage and macerated wound edges.</p> <p>Medical record review of wound care notes dated 1/27/16 revealed the sacral wound was still unstageable due to slough/eschar and measured 10.0 cm x 13.0 cm x 2.0 cm. Continued review revealed the wound bed was 100% slough and there was a small amount of serous drainage. Further review revealed there was undermining at 12,1 and the wound had a slight mal odor.</p> <p>Medical record review of a communication with the resident's personal physician revealed "...unstageable wound to sacrum showing decline. Modest amount of purulent drainage noted. Applied silvadene per (named wound care physician) orders. She continues to follow up with him next appt (appointment) is Feb. 15th. Any</p>	F 314			

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F 314	<p>Continued From page 6</p> <p>new orders?..." Continued review revealed the physician wrote "OK" on the communication. Further review revealed no notification of the wound care physician concerning the decline of the sacral pressure ulcer.</p> <p>Review of the Nursing Admission Assessment from the hospital dated 1/27/16 revealed Resident #4 had a Stage IV pressure ulcer to the coccyx which measured 10 cm x 6 cm x 3.5 cm with undermining with yellow slough in the middle and necrotic tissue around the edge and bloody drainage. Continued review revealed a Stage II pressure ulcer on the right buttock measuring 5 cm x 3.8 cm with yellow wound bed. Further review revealed a stage II pressure ulcer to the right buttock measuring 2 cm x 1.8 cm. Continued review revealed 4 stage II pressure ulcers around the rectum.</p> <p>Review of the admission History and Physical revealed under the skin assessment "...revealed a large stage IV decubitus ulcer measuring 6 or 8 cm across located in the decubitus area. There is some purulence in them, some surrounding redness and some shallow stage II ulcerations, 2 of which I saw just to the right of the larger decubitus ulcer..."</p> <p>Medical record review of a physician's note dated 2/13/16 revealed Resident #4 was transferred to the hospital for a "...large gaping coccygeal wound. Since discharge a culture has been obtained of her coccygeal wounds had has grown out E-Coli with ESBL characteristics (organisms normally in feces with antibiotic resistant tendency). She has a large decubitus ulcer that is at least a Grade 4 is noted on the coccygeal area that measures 6-8 cm. Continue wound care as is</p>	F 314			

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F 314	Continued From page 7 being done now. If it does not improve we may want to revisit another wound care evaluation..." Interview with the Director of Nursing (DON) on 8/16/16 at 2:20 PM in the Administrator's office revealed the Wound Care Nurse who treated the sacral ulcer of Resident #4 was no longer employed by the facility. Continued interview revealed the new Wound Care Nurse had only been in the position for 2 1/2 months. In further interview the DON confirmed the sacral ulcer was the only ulcer documented as being treated from admission on 12/22/15 through 1/27/16. Continued interview revealed without a picture it was difficult to read the wound reports since it was not clear in which direction the Wound Care Nurse was measuring due to inconsistent changes in measurements.	F 314			